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the grant program is not subject to review by States under part 100 of this title, which implements Executive Order 12372, “Intergovernmental Review of Federal Programs” (see part 100 of this title).

(b) *Review team.* A team consisting of staff from CMS and the Department of Health and Human Services will review all applications. The team will meet as necessary on an ongoing basis as applications are received.

(c) *Eligibility criteria.* To be eligible for a grant, a State must submit sufficient documentation that its high risk pool meets the eligibility requirements described in §148.310. A State must include sufficient documentation of the losses incurred in the operation of the qualified high risk pool in the period for when it is applying.

(d) *Review criteria.* If the review team determines that a State meets the eligibility requirements described in §148.310, the review team will use the following additional criteria in reviewing the applications:

(1) *Documentation of expenses incurred during operation of the qualified high risk pool.* The losses and expenses incurred in the operation of a State’s pool are sufficiently documented.

(2) *Funding mechanism.* The State has outlined funding sources, such as assessments and State general revenues, which can cover the projected costs and are reasonably designed to ensure continued funding of losses a State incurs in connection with the operation of the qualified high risk pool after fiscal year 2004.

§ 148.320 Grant awards.

(a) *Notification and award letter.* (1) Each State applicant will be notified in writing of CMS’s decision on its application.

(2) If the State applicant is awarded a grant, the award letter will contain the following terms and conditions:

(i) All funds awarded to the grantee under this program must be used exclusively for the operation of a qualified high risk pool that meets the eligibility requirements for this program.

(ii) The grantee must keep sufficient records of the grant expenditures for audit purposes (see part 92 of this title).

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(iii) The grantee may be required to submit quarterly progress and financial reports under part 92 of this title.

(b) *Grantees letter of acceptance.* Grantees must submit a letter of acceptance to CMS’ Acquisition and Grants Group within 30 days of the date of the award agreeing to the terms and conditions of the award letter.

PART 149 [RESERVED]

PART 150—CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS

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AUTHORITY: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

SOURCE: 64 FR 45795, Aug. 20, 1999, unless otherwise noted.

Subpart A—General Provisions

§ 150.101 Basis and scope.

(a) *Basis.* CMS's enforcement authority under sections 2722 and 2761 of the

PHS Act and its rulemaking authority under section 2792 of the PHS Act provide the basis for issuing regulations under this part 150.

(b) *Scope*—(1) *Enforcement with respect to group health plans.* The provisions of title XXVII of the PHS Act that apply to group health plans that are non-Federal governmental plans are enforced by CMS using the procedures described in § 150.301 *et seq.*

(2) *Enforcement with respect to health insurance issuers.* The States have primary enforcement authority with respect to the requirements of title XXVII of the PHS Act that apply to health insurance issuers offering coverage in the group or individual health insurance market. If CMS determines under subpart B of this part that a State is not substantially enforcing title XXVII of the PHS Act, including the implementing regulations in part 146 and part 148 of this subchapter, CMS enforces them under subpart C of this part.

§ 150.103 Definitions.

The definitions that appear in part 144 of this subchapter apply to this part 150, unless stated otherwise. As used in this part:

Amendment, endorsement, or rider means a document that modifies or changes the terms or benefits of an individual policy, group policy, or certificate of insurance.

Application means a signed statement of facts by a potential insured that an issuer uses as a basis for its decision whether, and on what basis to insure an individual, or to issue a certificate of insurance, or that a non-Federal governmental health plan uses as a basis for a decision whether to enroll an individual under the plan.

Certificate of insurance means the document issued to a person or entity covered under an insurance policy issued to a group health plan or an association or trust that summarizes the benefits and principal provisions of the policy.

Complaint means any expression, written or oral, indicating a potential denial of any right or protection contained in HIPAA requirements (whether ultimately justified or not) by an individual, a personal representative or

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other entity acting on behalf of an individual, or any entity that believes such a right is being or has been denied an individual.

Group health insurance policy or group policy means the legal document or contract issued by an issuer to a plan sponsor with respect to a group health plan (including a plan that is a non-Federal governmental plan) that contains the conditions and terms of the insurance that covers the group.

HIPAA requirements means the requirements of title XXVII of the PHS Act and its implementing regulations in parts 146 and 148 of this subchapter.

Individual health insurance policy or individual policy means the legal document or contract issued by the issuer to an individual that contains the conditions and terms of the insurance. Any association or trust arrangement that is not a group health plan as defined in §144.103 of this subchapter or does not provide coverage in connection with one or more group health plans is individual coverage subject to the requirements of part 148 of this subchapter. The term “individual health insurance policy” includes a policy that is—

(1) Issued to an association that makes coverage available to individuals other than in connection with one or more group health plans; or

(2) Administered, or placed in a trust, and is not sold in connection with a group health plan subject to the provisions of part 146 of this subchapter.

Plan document means the legal document that provides the terms of the plan to individuals covered under a group health plan, such as a non-Federal governmental health plan.

State law means all laws, decisions, rules, regulations, or other State action having the effect of law, of any State as defined in §144.103 of this subchapter. A law of the United States applicable to the District of Columbia is treated as a State law rather than a law of the United States.

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Subpart B—CMS Enforcement Processes for Determining Whether States Are Failing to Substantially Enforce HIPAA Requirements

§ 150.201 State enforcement.

Except as provided in subpart C of this part, each State enforces HIPAA requirements with respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State.

§ 150.203 Circumstances requiring CMS enforcement.

CMS enforces HIPAA requirements to the extent warranted (as determined by CMS) in any of the following circumstances:

(a) *Notification by State.* A State notifies CMS that it has not enacted legislation to enforce or that it is not otherwise enforcing HIPAA requirements.

(b) *Determination by CMS.* If CMS receives or obtains information that a State may not be substantially enforcing HIPAA requirements, it may initiate the process described in this subchapter to determine whether the State is failing to substantially enforce these requirements.

(c) *Special rule for guaranteed availability in the individual market.* If a State has notified CMS that it is implementing an acceptable alternative mechanism in accordance with §148.128 of this subchapter instead of complying with the guaranteed availability requirements of §148.120, CMS’s determination focuses on the following:

(1) Whether the State’s mechanism meets the requirements for an acceptable alternative mechanism.

(2) Whether the State is implementing the acceptable alternative mechanism.

(d) *Consequence of a State not implementing an alternative mechanism.* If a State is not implementing an acceptable alternative mechanism, CMS determines whether the State is substantially enforcing the requirements of §§148.101 through 148.126 and §148.170 of this subchapter.

§ 150.205 Sources of information triggering an investigation of State enforcement.

Information that may trigger an investigation of State enforcement includes, but is not limited to, any of the following:

- (a) A complaint received by CMS.
- (b) Information learned during informal contact between CMS and State officials.
- (c) A report in the news media.
- (d) Information from the governors and commissioners of insurance of the various States regarding the status of their enforcement of HIPAA requirements.
- (e) Information obtained during periodic review of State health care legislation. CMS may review State health care and insurance legislation and regulations to determine whether they are:
 - (1) Consistent with HIPAA requirements.
 - (2) Not pre-empted as provided in § 146.143 (relating to group market provisions) and § 148.120 (relating to individual market requirements) on the basis that they prevent the application of a HIPAA requirement.
- (f) Any other information that indicates a possible failure to substantially enforce.

§ 150.207 Procedure for determining that a State fails to substantially enforce HIPAA requirements.

Sections 150.209 through 150.219 describe the procedures CMS follows to determine whether a State is substantially enforcing HIPAA requirements.

§ 150.209 Verification of exhaustion of remedies and contact with State officials.

If CMS receives a complaint or other information indicating that a State is failing to enforce HIPAA requirements, CMS assesses whether the affected individual or entity has made reasonable efforts to exhaust available State remedies. As part of its assessment, CMS may contact State officials regarding the questions raised.

§ 150.211 Notice to the State.

If CMS is satisfied that there is a reasonable question whether there has

been a failure to substantially enforce HIPAA requirements, CMS sends, in writing, the notice described in § 150.213 of this part, to the following State officials:

- (a) The governor or chief executive officer of the State.
- (b) The insurance commissioner or chief insurance regulatory official.
- (c) If the alleged failure involves HMOs, the official responsible for regulating HMOs if different from the official listed in paragraph (b) of this section.

§ 150.213 Form and content of notice.

The notice provided to the State is in writing and does the following:

- (a) Identifies the HIPAA requirement or requirements that have allegedly not been substantially enforced.
- (b) Describes the factual basis for the allegation of a failure or failures to enforce HIPAA requirements.
- (c) Explains that the consequence of a State's failure to substantially enforce HIPAA requirements is that CMS enforces them.
- (d) Advises the State that it has 30 days from the date of the notice to respond, unless the time for response is extended as described in § 150.215 of this subpart. The State's response should include any information that the State wishes CMS to consider in making the preliminary determination described in § 150.217.

§ 150.215 Extension for good cause.

CMS may extend, for good cause, the time the State has for responding to the notice described in § 150.213 of this subpart. Examples of good cause include an agreement between CMS and the State that there should be a public hearing on the State's enforcement, or evidence that the State is undertaking expedited enforcement activities.

§ 150.217 Preliminary determination.

If, at the end of the 30-day period (and any extension), the State has not established to CMS's satisfaction that it is substantially enforcing the HIPAA requirements described in the notice, CMS takes the following actions:

- (a) Consults with the appropriate State officials identified in § 150.211 (or their designees).

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(b) Notifies the State of CMS's preliminary determination that the State has failed to substantially enforce the requirements and that the failure is continuing.

(c) Permits the State a reasonable opportunity to show evidence of substantial enforcement.

§ 150.219 Final determination.

If, after providing notice and a reasonable opportunity for the State to show that it has corrected any failure to substantially enforce, CMS finds that the failure to substantially enforce has not been corrected, it will send the State a written notice of its final determination. The notice includes the following:

(a) Identification of the HIPAA requirements that CMS is enforcing.

(b) The effective date of CMS's enforcement.

§ 150.221 Transition to State enforcement.

(a) If CMS determines that a State for which it has assumed enforcement authority has enacted and implemented legislation to enforce HIPAA requirements and also determines that it is appropriate to return enforcement authority to the State, CMS will enter into discussions with State officials to ensure that a transition is effected with respect to the following:

(1) Consumer complaints and inquiries.

(2) Instructions to issuers.

(3) Any other pertinent aspect of operations.

(b) CMS may also negotiate a process to ensure that, to the extent practicable, and as permitted by law, its records documenting issuer compliance and other relevant areas of CMS's enforcement operations are made available for incorporation into the records of the State regulatory authority that will assume enforcement responsibility.

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Subpart C—CMS Enforcement With Respect to Issuers and Non-Federal Governmental Plans—Civil Money Penalties

§ 150.301 General rule regarding the imposition of civil money penalties.

If any health insurance issuer that is subject to CMS's enforcement authority under § 150.101(b)(2), or any non-Federal governmental plan (or employer that sponsors a non-Federal governmental plan) that is subject to CMS's enforcement authority under § 150.101(b)(1), fails to comply with HIPAA requirements, it may be subject to a civil money penalty as described in this subpart.

§ 150.303 Basis for initiating an investigation of a potential violation.

(a) *Information.* Any information that indicates that any issuer may be failing to meet the HIPAA requirements or that any non-Federal governmental plan that is a group health plan as defined in section 2791(a)(1) of the PHS Act and 45 CFR § 144.103 may be failing to meet an applicable HIPAA requirement, may warrant an investigation. CMS may consider, but is not limited to, the following sources or types of information:

(1) Complaints.

(2) Reports from State insurance departments, the National Association of Insurance Commissioners, and other Federal and State agencies.

(3) Any other information that indicates potential noncompliance with HIPAA requirements.

(b) *Who may file a complaint.* Any entity or individual, or any entity or personal representative acting on that individual's behalf, may file a complaint with CMS if he or she believes that a right to which the aggrieved person is entitled under HIPAA requirements is being, or has been, denied or abridged as a result of any action or failure to act on the part of an issuer or other responsible entity as defined in § 150.305.

(c) *Where a complaint should be directed.* A complaint may be directed to any CMS regional office.

§ 150.305 Determination of entity liable for civil money penalty.

If a failure to comply is established under this Part, the responsible entity, as determined under this section, is liable for any civil money penalty imposed.

(a) *Health insurance issuer is responsible entity*—(1) *Group health insurance policy.* To the extent a group health insurance policy issued, sold, renewed, or offered to a private plan sponsor or a non-Federal governmental plan sponsor is subject to applicable HIPAA requirements, a health insurance issuer is subject to a civil money penalty, irrespective of whether a civil money penalty is imposed under paragraphs (b) or (c) of this section, if the policy itself or the manner in which the policy is marketed or administered fails to comply with an applicable HIPAA requirement.

(2) *Individual health insurance policy.* To the extent an individual health insurance policy is subject to an applicable HIPAA requirement, a health insurance issuer is subject to a civil money penalty if the policy itself, or the manner in which the policy is marketed or administered, violates any applicable HIPAA requirement.

(b) *Non-Federal governmental plan is responsible entity.* (1) *Basic rule.* If a non-Federal governmental plan is sponsored by two or more employers and fails to comply with an applicable HIPAA requirement, the plan is subject to a civil money penalty, irrespective of whether a civil money penalty is imposed under paragraph (a) of this section. The plan is the responsible entity irrespective of whether the plan is administered by a health insurance issuer, an employer sponsoring the plan, or a third-party administrator.

(2) *Exception.* In the case of a non-Federal governmental plan that is not provided through health insurance coverage, this paragraph (b) does not apply to the extent that the non-Federal governmental employers have elected under § 146.180 to exempt the plan from applicable HIPAA requirements.

(c) *Employer is responsible entity.* (1) *Basic rule.* If a non-Federal governmental plan is sponsored by a single employer and fails to comply with an applicable HIPAA requirement, the employer is subject to a civil money

penalty, irrespective of whether a civil money penalty is imposed under paragraph (a) of this section. The employer is the responsible entity irrespective of whether the plan is administered by a health insurance issuer, the employer, or a third-party administrator.

(2) *Exception.* In the case of a non-Federal governmental plan that is not provided through health insurance coverage, this paragraph (c) does not apply to the extent the non-Federal governmental employer has elected under § 146.180 to exempt the plan from applicable HIPAA requirements.

(d) *Actions or inactions of agent.* A principal is liable for penalties assessed for the actions or inactions of its agent.

§ 150.307 Notice to responsible entities.

If an investigation under § 150.303 indicates a potential violation, CMS provides written notice to the responsible entity or entities identified under § 150.305. The notice does the following:

(a) Describes the substance of any complaint or other information. (See Appendix A to this subpart for examples of violations.)

(b) Provides 30 days from the date of the notice for the responsible entity or entities to respond with additional information, including documentation of compliance as described in § 150.311.

(c) States that a civil money penalty may be assessed.

§ 150.309 Request for extension.

In circumstances in which an entity cannot prepare a response to CMS within the 30 days provided in the notice, the entity may make a written request for an extension from CMS detailing the reason for the extension request and showing good cause. If CMS grants the extension, the responsible entity must respond to the notice within the time frame specified in CMS's letter granting the extension of time. Failure to respond within 30 days, or within the extended time frame, may result in CMS's imposition of a civil money penalty based upon the complaint or other information alleging or indicating a violation of HIPAA requirements.

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§ 150.311 Responses to allegations of noncompliance.

In determining whether to impose a civil money penalty, CMS reviews and considers documentation provided in any complaint or other information, as well as any additional information provided by the responsible entity to demonstrate that it has complied with HIPAA requirements. The following are examples of documentation that a potential responsible entity may submit for CMS's consideration in determining whether a civil money penalty should be assessed and the amount of any civil money penalty:

(a) Any individual policy, group policy, certificate of insurance, application, rider, amendment, endorsement, certificate of creditable coverage, advertising material, or any other documents if those documents form the basis of a complaint or allegation of noncompliance, or the basis for the responsible entity to refute the complaint or allegation.

(b) Any other evidence that refutes an alleged noncompliance.

(c) Evidence that the entity did not know, and exercising due diligence could not have known, of the violation.

(d) Documentation that the policies, certificates of insurance, or non-Federal governmental plan documents have been amended to comply with HIPAA requirements either by revision of the contracts or by the development of riders, amendments, or endorsements.

(e) Documentation of the entity's issuance of conforming policies, certificates of insurance, plan documents, or amendments to policyholders or certificate holders before the issuance of the notice of intent to assess a penalty described in § 150.307.

(f) Evidence documenting the development and implementation of internal policies and procedures by an issuer, or non-Federal governmental health plan or employer, to ensure compliance with HIPAA requirements. Those policies and procedures may include or consist of a voluntary compliance program. Any such program should do the following:

(1) Effectively articulate and demonstrate the fundamental mission of compliance and the issuer's, or non-

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Federal governmental health plan's or employer's, commitment to the compliance process.

(2) Include the name of the individual in the organization responsible for compliance.

(3) Include an effective monitoring system to identify practices that do not comply with HIPAA requirements and to provide reasonable assurance that fraud, abuse, and systemic errors are detected in a timely manner.

(4) Address procedures to improve internal policies when noncompliant practices are identified.

(g) Evidence documenting the entity's record of previous compliance with HIPAA requirements.

§ 150.313 Market conduct examinations.

(a) *Definition.* A market conduct examination means the examination of health insurance operations of an issuer, or the operation of a non-Federal governmental plan, involving the review of one or more (or a combination) of a responsible entity's business or operational affairs, or both, to verify compliance with HIPAA requirements.

(b) *General.* If, based on the information described in § 150.303, CMS finds evidence that a specific entity may be in violation of a HIPAA requirement, CMS may initiate a market conduct examination to determine whether the entity is out of compliance. CMS may conduct the examinations either at the site of the issuer or other responsible entity or a site CMS selects. When CMS selects a site, it may direct the issuer or other responsible entity to forward any documentation CMS considers relevant for purposes of the examination to that site.

(c) *Appointment of examiners.* When CMS identifies an issue that warrants investigation, CMS will appoint one or more examiners to perform the examination and instruct them as to the scope of the examination.

(d) *Appointment of professionals and specialists.* When conducting an examination under this part, CMS may retain attorneys, independent actuaries, independent market conduct examiners, or other professionals and specialists as examiners.

(e) *Report of market conduct examination.* (1) *CMS review.* When CMS receives a report, it will review the report, together with the examination work papers and any other relevant information, and prepare a final report. The final examination report will be provided to the issuer or other responsible entity.

(2) *Response from issuer or other responsible entity.* With respect to each examination issue identified in the report, the issuer or other responsible entity may:

(i) Concur with CMS's position(s) as outlined in the report, explaining the plan of correction to be implemented.

(ii) Dispute CMS's position(s), clearly outlining the basis for its dispute and submitting illustrative examples where appropriate.

(3) *CMS's reply to a response from an issuer or other responsible entity.* Upon receipt of a response from the issuer or other responsible entity, CMS will provide a letter containing its reply to each examination issue. CMS's reply will consist of one of the following:

(i) Concurrence with the issuer's or non-Federal governmental plan's position.

(ii) Approval of the issuer's or non-Federal governmental plan's proposed plan of correction.

(iii) Conditional approval of the issuer's or non-Federal governmental plan's proposed plan of correction, which will include any modifications CMS requires.

(iv) Notice to the issuer or non-Federal governmental plan that there exists a potential violation of HIPAA requirements.

§ 150.315 Amount of penalty—General.

A civil money penalty for each violation of 42 U.S.C. 300gg *et seq.* may not exceed \$100 for each day, for each responsible entity, for each individual affected by the violation. Penalties imposed under this part are in addition to any other penalties prescribed or allowed by law.

§ 150.317 Factors CMS uses to determine the amount of penalty.

In determining the amount of any penalty, CMS takes into account the following:

(a) *The entity's previous record of compliance.* This may include any of the following:

(1) Any history of prior violations by the responsible entity, including whether, at any time before determination of the current violation or violations, CMS or any State found the responsible entity liable for civil or administrative sanctions in connection with a violation of HIPAA requirements.

(2) Documentation that the responsible entity has submitted its policy forms to CMS for compliance review.

(3) Evidence that the responsible entity has never had a complaint for non-compliance with HIPAA requirements filed with a State or CMS.

(4) Such other factors as justice may require.

(b) *The gravity of the violation.* This may include any of the following:

(1) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread.

(2) The level of financial and other impacts on affected individuals.

(3) Other factors as justice may require.

§ 150.319 Determining the amount of the penalty—mitigating circumstances.

For every violation subject to a civil money penalty, if there are substantial or several mitigating circumstances, the aggregate amount of the penalty is set at an amount sufficiently below the maximum permitted by § 150.315 to reflect that fact. As guidelines for taking into account the factors listed in § 150.317, CMS considers the following:

(a) *Record of prior compliance.* It should be considered a mitigating circumstance if the responsible entity has done any of the following:

(1) Before receipt of the notice issued under § 150.307, implemented and followed a compliance plan as described in § 150.311(f).

(2) Had no previous complaints against it for noncompliance.

(b) *Gravity of the violation(s).* It should be considered a mitigating circumstance if the responsible entity has done any of the following:

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(1) Made adjustments to its business practices to come into compliance with HIPAA requirements so that the following occur:

(i) All employers, employees, individuals and non-Federal governmental entities are identified that are or were issued any policy, certificate of insurance or plan document, or any form used in connection therewith that failed to comply.

(ii) All employers, employees, individuals, and non-Federal governmental plans are identified that were denied coverage or were denied a right provided under HIPAA requirements.

(iii) Each employer, employee, individual, or non-Federal governmental plan adversely affected by the violation has been, for example, offered coverage or provided a certificate of creditable coverage in a manner that complies with HIPAA requirements that were violated so that, to the extent practicable, that employer, employee, individual, or non-Federal governmental entity is in the same position that he, she, or it would have been in had the violation not occurred.

(iv) The adjustments are completed in a timely manner.

(2) Discovered areas of noncompliance without notice from CMS and voluntarily reported that noncompliance, provided that the responsible entity submits the following:

(i) Documentation verifying that the rights and protections of all individuals adversely affected by the non-compliance have been restored; and

(ii) A plan of correction to prevent future similar violations.

(3) Demonstrated that the violation is an isolated occurrence.

(4) Demonstrated that the financial and other impacts on affected individuals is negligible or nonexistent.

(5) Demonstrated that the non-compliance is correctable and that a high percentage of the violations were corrected.

§ 150.321 Determining the amount of penalty—aggravating circumstances.

For every violation subject to a civil money penalty, if there are substantial or several aggravating circumstances, CMS sets the aggregate amount of the

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penalty at an amount sufficiently close to or at the maximum permitted by § 150.315 to reflect that fact. CMS considers the following circumstances to be aggravating circumstances:

(a) The frequency of violation indicates a pattern of widespread occurrence.

(b) The violation(s) resulted in significant financial and other impacts on the average affected individual.

(c) The entity does not provide documentation showing that substantially all of the violations were corrected.

§ 150.323 Determining the amount of penalty—other matters as justice may require.

CMS may take into account other circumstances of an aggravating or mitigating nature if, in the interests of justice, they require either a reduction or an increase of the penalty in order to assure the achievement of the purposes of this part, and if those circumstances relate to the entity's previous record of compliance or the gravity of the violation.

§ 150.325 Settlement authority.

Nothing in §§ 150.315 through 150.323 limits the authority of CMS to settle any issue or case described in the notice furnished in accordance with § 150.307 or to compromise on any penalty provided for in §§ 150.315 through 150.323.

§ 150.341 Limitations on penalties.

(a) *Circumstances under which a civil money penalty is not imposed.* CMS does not impose any civil money penalty on any failure for the period of time during which none of the responsible entities knew, or exercising reasonable diligence would have known, of the failure. CMS also does not impose a civil money penalty for the period of time after any of the responsible entities knew, or exercising reasonable diligence would have known of the failure, if the failure was due to reasonable cause and not due to willful neglect and the failure was corrected within 30 days of the first day that any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the failure existed.

(b) *Burden of establishing knowledge.* The burden is on the responsible entity or entities to establish to CMS's satisfaction that no responsible entity knew, or exercising reasonable diligence would have known, that the failure existed.

§ 150.343 Notice of proposed penalty.

If CMS proposes to assess a penalty in accordance with this part, it delivers to the responsible entity, or sends to that entity by certified mail, return receipt requested, written notice of its intent to assess a penalty. The notice includes the following:

(a) A description of the HIPAA requirements that CMS has determined that the responsible entity violated.

(b) A description of any complaint or other information upon which CMS based its determination, including the basis for determining the number of affected individuals and the number of days for which the violations occurred.

(c) The amount of the proposed penalty as of the date of the notice.

(d) Any circumstances described in §§ 150.317 through 150.323 that were considered when determining the amount of the proposed penalty.

(e) A specific statement of the responsible entity's right to a hearing.

(f) A statement that failure to request a hearing within 30 days permits the assessment of the proposed penalty without right of appeal in accordance with § 150.347.

§ 150.345 Appeal of proposed penalty.

Any entity against which CMS has assessed a penalty may appeal that penalty in accordance with § 150.401 *et seq.*

§ 150.347 Failure to request a hearing.

If the responsible entity does not request a hearing within 30 days of the issuance of the notice described in § 150.343, CMS may assess the proposed civil money penalty, a less severe penalty, or a more severe penalty. CMS notifies the responsible entity in writing of any penalty that has been assessed and of the means by which the responsible entity may satisfy the judgment. The responsible entity has no right to appeal a penalty with respect to which it has not requested a

hearing in accordance with § 150.405 unless the responsible entity can show good cause, as determined under § 150.405(b), for failing to timely exercise its right to a hearing.

APPENDIX A TO SUBPART C OF PART 150—EXAMPLES OF VIOLATIONS

This appendix lists actions in the group and individual markets for which CMS may impose civil money penalties. This list is not all-inclusive.

NOTE 1: All cross-references to sections of the Code of Federal Regulations are cross-references to sections in parts 144, 146, or 148 of this subchapter.

NOTE 2: Except as otherwise expressly noted, all references to non-Federal governmental plans refer to non-Federal governmental plans that are *not* exempt from HIPAA requirements (as defined in § 150.103) under section 2721(b)(2) of the PHS Act and § 146.180.

I. Basis for Imposition of Civil Money Penalties—Actions in the Group Market

a. Failure to comply with the limitations on pre-existing condition exclusions (§ 146.111).

Violations of the limitations on pre-existing condition exclusions, set forth in § 146.111, includes those circumstances in which a non-Federal governmental plan or health insurance issuer offering group health insurance coverage does the following:

(1) Imposes a preexisting condition exclusion period that exceeds 12 months or, in the case of a late enrollee, 18 months, from the enrollment date (the first day of coverage or the first day of the waiting period, if any).

(2) Fails to reduce a pre-existing condition exclusion period by creditable coverage as provided in §§ 146.111(a)(1)(iii) and 146.113.

(3) Imposes a pre-existing condition exclusion period without first giving the two written notices required in §§ 146.111(c) and 146.115(d). The first notice is a general notice to all plan participants of the existence and terms of any pre-existing condition exclusion under the plan, and the rights of individuals to demonstrate creditable coverage. The notice should explain the right of an individual to request a certificate from a previous plan or issuer, if necessary, and include a statement that the current plan or issuer will assist in obtaining a certificate from a previous plan or issuer, if necessary. The second notice is required to be sent to any individual who has presented evidence of creditable coverage, and to whom a pre-existing condition exclusion period will be applied. This second notice informs the individual of the plan's determination of any pre-existing condition exclusion period, the basis for such determination, a written explanation of any

appeals procedures established by the plan or issuer, and a reasonable opportunity to submit additional evidence of creditable coverage.

(4) Treats pregnancy as a pre-existing condition, as prohibited by § 146.111(b)(4). For example, an issuer may not refuse to pay for prenatal care and delivery effective with the date maternity coverage began because the individual did not have maternity coverage at the time the pregnancy began.

(5) Imposes a pre-existing condition exclusion with regard to a child who enrolls in a group health plan within 30 days of birth, adoption, or placement for adoption.

(6) Imposes a pre-existing condition exclusion with regard to a child who was enrolled in another group health plan within 30 days of birth, adoption, or placement for adoption and who does not experience significant break in coverage.

(7) Uses a pre-existing condition look-back period that exceeds the six-month period ending on the enrollment date in violation of § 146.111(a)(1) of this chapter.

(8) Determines whether a pre-existing condition exclusion applies by using a standard other than whether medical advice, diagnosis, care, or treatment was actually recommended or received during the look-back period. A determination that a reasonably prudent person would or should have sought medical care for the condition is an unacceptable standard by which to determine whether a pre-existing condition exclusion applies.

(9) Uses genetic information as part of the definition of pre-existing condition in the absence of a diagnosis of the condition related to the genetic information.

(10) Otherwise fails to comply with § 146.111.

b. Failure to comply with the provisions relating to creditable coverage (§ 146.113).

Failure to comply with the § 146.113 rules relating to creditable coverage includes those circumstances in which a non-Federal governmental plan or issuer offering group health insurance coverage does the following:

(1) Fails to treat all forms of coverage listed in § 146.113(a) as creditable coverage.

(2) Counts creditable coverage in a manner inconsistent with the standard method described in § 146.113(b) or the alternative method described in § 146.113(c), if it elects to use the alternative method.

(3) Treats an individual with fewer than 63 consecutive days without creditable coverage as having a significant break in coverage in violation of § 146.113(b)(2)(iii).

(4) Takes either a waiting period or an affiliation period into account when calculating a significant break in coverage, as prohibited by § 146.113(b)(2)(iii).

(5) Otherwise fails to comply with § 146.113.

c. Failure to comply with the provisions regarding certification and disclosure of previous coverage (§ 146.115).

Except as provided in paragraph (c)(b), the plan sponsor of a self-funded non-Federal governmental plan may not elect to exempt its plan from the requirements of this paragraph.

Failure to comply with the requirements in § 146.115 regarding certification and disclosure of previous coverage includes those circumstances in which a non-Federal governmental plan or issuer offering group health insurance coverage does the following:

(1) Fails to ensure that individuals who request certification receive it.

(2) Fails to automatically provide certificates of creditable coverage promptly, either—

(i) When the individual ceases to be covered under the plan (whether or not COBRA continuation coverage is offered or elected); or

(ii) When the COBRA continuation coverage is exhausted or is terminated by the individual, if COBRA continuation coverage was offered and was elected.

(3) Fails to provide certificates of creditable coverage promptly upon request.

(4) Fails to provide the required information in certificates of creditable coverage.

(5) Fails to provide certificates of creditable coverage to dependents.

(6) Fails to accept other evidence of creditable coverage as provided in § 146.115(c). (The plan sponsor of a self-funded non-Federal governmental plan may elect to exempt its plan from the requirements of this paragraph (6)).

(7) Otherwise fails to comply with § 146.115.

d. Failure to comply with the provisions regarding special enrollment periods (§ 146.117).

Failure to comply with the § 146.117 requirements regarding special enrollment periods includes those circumstances in which an issuer or a non-Federal governmental plan does the following:

(1) Fails to permit employees and dependents to enroll for coverage if they satisfy the conditions of § 146.117(a) or (b).

(2) Fails to provide coverage on a timely basis to individuals protected by a special enrollment period as provided in § 146.117.

(3) Fails to provide the employee with a description of the plan's or issuer's special enrollment rules on or before the time the employee is offered the opportunity to enroll as provided in § 146.117(c).

(4) Otherwise fails to comply with § 146.117.

e. Failure to comply with the HMO affiliation period provisions (§ 146.119).

Failure to comply with the § 146.119 affiliation period requirements includes those circumstances in which an HMO that offers group health insurance coverage does the following:

(1) Imposes a pre-existing condition exclusion period.

(2) Charges a premium for months in an affiliation period.

(3) Fails to impose an affiliation period uniformly without regard to any health status-related factor.

(4) Imposes an affiliation period that is longer than 2 months (or 3 months for late enrollees), or one that begins later than the enrollment date or does not run concurrently with any waiting period.

(5) Otherwise fails to comply with § 146.119. f. Failure to comply with the provisions regarding nondiscrimination (§ 146.121).

Failure to comply with the § 146.121 prohibitions regarding nondiscrimination includes those circumstances in which an issuer or a non-Federal governmental plan does the following:

(1) Applies rules of eligibility (including continued eligibility) to enroll under the terms of the plan based any of the health-status related factors described in § 146.121(a).

(2) Requires an individual as a condition of enrollment or re-enrollment to pay a higher premium than others similarly situated by reason of a health-status related factor of the individual or the individual's dependent.

(3) Otherwise fails to comply with § 146.121.

g. Failure to comply with the provisions relating to benefits for mothers and newborns (§ 146.130) in States where the § 146.130 standards are applicable.

Failure of an issuer or a non-Federal governmental plan to comply with the standards in § 146.130 relating to benefits for mothers and newborns includes the following:

(1) Restricts benefits for a mother or her newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section, unless the attending provider decides, in consultation with the mother, to discharge the mother or newborn earlier.

(2) Fails to calculate the length of stay from the time of delivery when delivery occurs in a hospital, or from the time of admission when delivery occurs outside the hospital.

(3) Penalizes an attending provider for complying with the law.

(4) Offers incentives to an attending provider to provide care in a manner inconsistent with the provisions of § 146.130.

(5) Denies the mother or newborn eligibility or continued eligibility to enroll under the plan to avoid complying with § 146.130.

(6) Provides payments or rebates to mothers to encourage them to accept less than the minimum stay required.

(7) Requires an attending provider to obtain authorization to prescribe a hospital length of stay of up to 48 hours (or 96 hours) after delivery.

(8) Imposes deductibles, coinsurance, or other cost-sharing measures for any portion of a 48-hour (or 96-hour) hospital stay that are less favorable than those imposed on any preceding portion of the stay.

(9) In the case of a non-Federal governmental plan, fails to provide participants and beneficiaries with a statement describing the requirements of the Newborns' and Mothers' Health Protection Act of 1996, using the language provided at § 146.130(d)(2), not later than 60 days after the first day of the first plan year beginning on or after January 1, 1999.

(10) Otherwise fails to comply with § 146.130.

h. Failure to comply with the provisions pertaining to parity in the application of certain limits to mental health benefits in the large group market (§ 146.136).

Failure of a non-Federal governmental plan offered by a large employer or health insurance issuer offering health insurance coverage to large employers to comply with the § 146.136 provisions pertaining to parity in the application of certain limits to mental health benefits (with respect to a plan that must comply with such provisions) includes the following:

(1) Sale of a product by a health insurance issuer that fails to comply with the mental health parity provisions of § 146.136.

(2) Failure of a non-Federal governmental plan to comply with the annual and lifetime dollar limits provisions concerning mental health parity.

i. Failure to comply with the Women's Health and Cancer Rights Act of 1998 (section 2706 of the PHS Act, 42 U.S.C. 300gg-06).

j. Failure to comply with the provisions regarding guaranteed availability of coverage in the small group market (§ 146.150).

Failure to provide guaranteed availability in the small group market as provided in § 146.150 includes those circumstances in which a health insurance issuer offering any health insurance coverage to group health plans in the small group market does the following:

(1) Fails to offer all products on a guaranteed availability basis to all small employers.

(2) Fails to define a small employer using the definition at § 144.103, unless otherwise provided under State law; that is, generally an employer with between 2 and 50 employees.

(3) Fails to count as employees all individual employees that an employer wants to include in the group by applying a more restrictive definition of "employee" than is permitted by § 144.103.

(4) Fails to accept all employee dependents who are qualified under the terms of the employer's group health plan.

(5) Sets agent commissions for sales to small employers so low as to discourage

agents from marketing policies to, or enrolling, these groups so that a failure to offer coverage results.

(6) Unreasonably delays the processing of applications submitted by small employers, so that a break in coverage of more than 63 days results.

(7) Fails to offer to any small employer on a guaranteed availability basis any product that the issuer sells to small employers through one or more associations that are not bona fide associations, as defined in §144.103. The requirement to guarantee availability of such products to all small employers applies whether or not the small employer is a member of, or could qualify for membership in, that association.

(8) Otherwise fails to comply with §146.150.

k. Failure to comply with the requirements regarding guaranteed renewability in either the large or small group market (§146.152).

Failure to provide guaranteed renewability of coverage as provided in §146.152 includes those circumstances in which a health insurance issuer offering health insurance coverage to a group health plan in the small or large group market does the following:

(1) Fails to renew or continue in force coverage at the option of the plan sponsor unless one of the specific exceptions in §146.152(b) is met.

(2) Fails to follow the requirements as described in §146.152(c)–(e) relating to the discontinuance of a particular product or withdrawal from the market of a particular product.

(3) Fails to renew coverage of an individual employer who has been a member of an association when the individual employer ceases to be a member of the association, unless it is a bona fide association as defined in §144.103, and the issuer terminates coverage for all former members on a uniform basis.

(4) Fails to act uniformly if the issuer cancels coverage.

(5) Otherwise fails to comply with §146.152.

l. Failure to comply with the requirements relating to disclosure of information (§146.160).

Failure to make reasonable disclosure as provided in §146.160 includes those circumstances in which an issuer offering group health insurance coverage to a small employer, as defined in §144.103, does the following:

(1) Fails to disclose all information concerning all products available from the issuer in the small group market as defined in §144.103.

(2) Otherwise fails to comply with §146.160.

II. Basis for Imposition of Civil Money Penalties—Actions in the Individual Market

a. Failure to comply with the requirements regarding guaranteed availability of coverage (§148.120).

In States that are not implementing an acceptable alternative mechanism described in §148.128, failure to provide guaranteed availability with no preexisting condition exclusion period as provided in §148.120 includes those circumstances in which an issuer does the following:

(1) Fails to provide to eligible individuals, on a guaranteed availability basis, at least one of the following:

(i) Enrollment in all individual market policies it actually markets.

(ii) The two most popular policies described in §148.120(c)(2).

(iii) Two representative policy forms as described in §148.120(c)(3).

(2) Imposes any preexisting condition exclusion or affiliation period on eligible individuals under any policy that it sells on a guaranteed availability basis.

(3) Sets agent commissions for sales to eligible individuals so low as to discourage agents from marketing policies to, or enrolling, these individuals so that a failure to offer coverage results.

(4) Unreasonably delays the processing of applications submitted by eligible individuals.

(5) Fails to offer to any eligible individual as defined in §148.103 (on a guaranteed availability basis with no preexisting condition exclusions) any product the issuer sells to individuals through one or more associations that are not bona fide associations, as defined in §144.103, unless the issuer has designated at least two other products (as its two most popular or its two representative policies) that it will sell to eligible individuals.

(6) Denies an eligible individual a policy on the basis that the individual has had a significant break in coverage even though a substantially complete application was filed on or before the 63rd day after the prior group coverage ended.

(7) Otherwise fails to comply with §148.120.

b. Failure to comply with the requirements regarding guaranteed renewability of coverage (§148.122).

Failure to provide guaranteed renewability as provided in §148.122 includes those circumstances in which an issuer does the following:

(1) Fails to renew or continue in force coverage at the option of the individual, unless one of the specific exceptions in §148.122 is met.

(2) Fails to follow the requirements relating to the discontinuance of a particular product or withdrawal from the market of a particular product as described in §148.122(d).

(3) Fails to continue coverage at the option of the individual after the individual becomes eligible for Medicare.

(4) Fails to renew coverage for an individual who has been a member of an association when the individual ceases to be a member of the association, unless the association is a bona fide association as defined in § 144.103 and the issuer uniformly terminates coverage for all former members.

(5) Otherwise fails to comply with § 148.122.

c. Failure to comply with the requirements regarding certification and disclosure of coverage (§ 148.124).

Failure to comply with the requirements of § 148.124 regarding certification and disclosure of previous coverage includes those circumstances in which an issuer does any of the following:

(1) Fails to provide automatic certificates of creditable coverage promptly.

(2) Fails to disclose the required information in certificates of creditable coverage as provided in § 148.124(b).

(3) Fails to provide certificates of creditable coverage to dependents who are insured in the individual market and whose coverage ceases under an individual policy.

(4) Fails to credit coverage or establish eligibility as provided in § 148.124 solely because the individual is unable to obtain a certificate. This includes failing to accept, acknowledge, consider, or otherwise use other evidence of creditable coverage described in § 146.115(c) submitted by, or on behalf of, an individual to establish that person is an eligible individual.

(5) Otherwise fails to comply with § 148.124.

d. Failure to comply with the requirements regarding determination of an eligible individual (§ 148.126).

Failure to determine, as provided in § 148.126, that an applicant for health insurance is an eligible individual includes those circumstances in which an issuer does the following:

(1) Fails to identify eligible individuals, to provide information regarding all coverage options, and to issue policies promptly.

(2) Requires eligible individuals to specify their desire to invoke the requirements of part 148 or to explicitly request their rights under the law in order to obtain information about products available to them.

(3) Otherwise fails to comply with § 148.126.

e. Failure to comply with the standards relating to benefits for mothers and newborns (§ 148.170).

In States where the § 148.170 standards are applicable (see § 148.170(e)), failure to comply with the § 148.170 standards relating to benefits for mothers and newborns includes those circumstances in which a health insurance issuer does the following:

(1) Restricts benefits for a mother or her newborn to fewer than 48 hours following a vaginal delivery or fewer than 96 hours following a delivery by cesarean section, unless the attending provider decides, in consulta-

tion with the mother, to discharge the mother or newborn earlier.

(2) Fails to calculate the length of stay from the time of delivery when delivery occurs in a hospital, or from the time of admission when delivery occurs outside the hospital.

(3) Requires an attending provider to obtain authorization to prescribe a hospital length of stay of up to 48 hours (or 96 hours, if applicable) after delivery.

(4) Imposes deductibles, coinsurance, or other cost-sharing measures for any portion of a 48-hour (or 96-hour, if applicable) hospital stay that are less favorable than those imposed on any preceding portion of the stay.

(5) [Reserved]

(6) Penalizes a provider for complying with the law.

(7) Offers incentives to a provider to provide care in a manner inconsistent with the provisions of § 148.170 to avoid complying with § 148.170.

(8) Denies the mother or newborn eligibility or continued eligibility solely to avoid the requirements of § 148.170.

(9) Provides incentives to mothers to encourage them to accept less than the minimum stay requirement.

(10) Fails to provide participants and beneficiaries with a statement describing the requirements of the Newborns' and Mothers' Health Protection Act of 1996, using the language provided at § 148.170 (d)(2), not later than March 1, 1999.

(11) Otherwise fails to comply with § 148.170.

f. Failure to comply with the Women's Health and Cancer Rights Act of 1998 (section 2752 of the PHS Act, 42 U.S.C. 300gg-52) and any additional implementing regulations.

Subpart D—Administrative Hearings

§ 150.401 Definitions.

In this subpart, unless the context indicates otherwise:

ALJ means administrative law judge of the Departmental Appeals Board of the Department of Health and Human Services.

Filing date means the date post-marked by the U.S. Postal Service, deposited with a carrier for commercial delivery, or hand delivered.

Hearing includes a hearing on a written record as well as an in-person or telephone hearing.

Party means CMS or the respondent.

Receipt date means five days after the date of a document, unless there is a

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showing that it was in fact received later.

Respondent means an entity that received a notice of proposed assessment of a civil money penalty issued pursuant to § 150.343.

§ 150.403 Scope of ALJ's authority.

(a) The ALJ has the authority, including all of the authority conferred by the Administrative Procedure Act, to adopt whatever procedures may be necessary or proper to carry out in an efficient and effective manner the ALJ's duty to provide a fair and impartial hearing on the record and to issue an initial decision concerning the imposition of a civil money penalty.

(b) The ALJ's authority includes the authority to modify, consistent with the Administrative Procedure Act (5 U.S.C. 552a), any hearing procedures set out in this subpart.

(c) The ALJ does not have the authority to find invalid or refuse to follow Federal statutes or regulations.

§ 150.405 Filing of request for hearing.

(a) A respondent has a right to a hearing before an ALJ if it files a request for hearing that complies with § 150.407(a), within 30 days after the date of issuance of either CMS's notice of proposed assessment under § 150.343 or notice that an alternative dispute resolution process has terminated. The request for hearing should be addressed as instructed in the notice of proposed determination. "Date of issuance" is five (5) days after the filing date, unless there is a showing that the document was received earlier.

(b) The ALJ may extend the time for filing a request for hearing only if the ALJ finds that the respondent was prevented by events or circumstances beyond its control from filing its request within the time specified above. Any request for an extension of time must be made promptly by written motion.

§ 150.407 Form and content of request for hearing.

(a) The request for hearing must do the following:

(1) Identify any factual or legal bases for the assessment with which the respondent disagrees.

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(2) Describe with reasonable specificity the basis for the disagreement, including any affirmative facts or legal arguments on which the respondent is relying.

(b) The request for hearing must identify the relevant notice of assessment by date and attach a copy of the notice.

§ 150.409 Amendment of notice of assessment or request for hearing.

The ALJ may permit CMS to amend its notice of assessment, or permit the respondent to amend a request for hearing that complies with § 150.407(a), if the ALJ finds that no undue prejudice to either party will result.

§ 150.411 Dismissal of request for hearing.

An ALJ will order a request for hearing dismissed if the ALJ determines that:

(a) The request for hearing was not filed within 30 days as specified by § 150.405(a) or any extension of time granted by the ALJ pursuant to § 150.405(b).

(b) The request for hearing fails to meet the requirements of § 150.407.

(c) The entity that filed the request for hearing is not a respondent under § 150.401.

(d) The respondent has abandoned its request.

(e) The respondent withdraws its request for hearing.

§ 150.413 Settlement.

CMS has exclusive authority to settle any issue or any case, without the consent of the administrative law judge at any time before or after the administrative law judge's decision.

§ 150.415 Intervention.

(a) The ALJ may grant the request of an entity, other than the respondent, to intervene if all of the following occur:

(1) The entity has a significant interest relating to the subject matter of the case.

(2) Disposition of the case will, as a practical matter, likely impair or impede the entity's ability to protect that interest.

(3) The entity's interest is not adequately represented by the existing parties.

(4) The intervention will not unduly delay or prejudice the adjudication of the rights of the existing parties.

(b) A request for intervention must specify the grounds for intervention and the manner in which the entity seeks to participate in the proceedings. Any participation by an intervenor must be in the manner and by any deadline set by the ALJ.

(c) The Department of Labor or the IRS may intervene without regard to paragraphs (a)(1) through (a)(3) of this section.

§ 150.417 Issues to be heard and decided by ALJ.

(a) The ALJ has the authority to hear and decide the following issues:

(1) Whether a basis exists to assess a civil money penalty against the respondent.

(2) Whether the amount of the assessed civil money penalty is reasonable.

(b) In deciding whether the amount of a civil money penalty is reasonable, the ALJ—

(1) Applies the factors that are identified in § 150.317.

(2) May consider evidence of record relating to any factor that CMS did not apply in making its initial determination, so long as that factor is identified in this subpart.

(c) If the ALJ finds that a basis exists to assess a civil money penalty, the ALJ may sustain, reduce, or increase the penalty that CMS assessed.

§ 150.419 Forms of hearing.

(a) All hearings before an ALJ are on the record. The ALJ may receive argument or testimony in writing, in person, or by telephone. The ALJ may receive testimony by telephone only if the ALJ determines that doing so is in the interest of justice and economy and that no party will be unduly prejudiced. The ALJ may require submission of a witness' direct testimony in writing only if the witness is available for cross-examination.

(b) The ALJ may decide a case based solely on the written record where there is no disputed issue of material

fact the resolution of which requires the receipt of oral testimony.

§ 150.421 Appearance of counsel.

Any attorney who is to appear on behalf of a party must promptly file, with the ALJ, a notice of appearance.

§ 150.423 Communications with the ALJ.

No party or person (except employees of the ALJ's office) may communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for both parties to participate. This provision does not prohibit a party or person from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 150.425 Motions.

(a) Any request to the ALJ for an order or ruling must be by motion, stating the relief sought, the authority relied upon, and the facts alleged. All motions must be in writing, with a copy served on the opposing party, except in either of the following situations:

(1) The motion is presented during an oral proceeding before an ALJ at which both parties have the opportunity to be present.

(2) An extension of time is being requested by agreement of the parties or with waiver of objections by the opposing party.

(b) Unless otherwise specified in this subpart, any response or opposition to a motion must be filed within 20 days of the party's receipt of the motion. The ALJ does not rule on a motion before the time for filing a response to the motion has expired except where the response is filed at an earlier date, where the opposing party consents to the motion being granted, or where the ALJ determines that the motion should be denied.

§ 150.427 Form and service of submissions.

(a) Every submission filed with the ALJ must be filed in triplicate, including one original of any signed documents, and include:

(1) A caption on the first page, setting forth the title of the case, the

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docket number (if known), and a description of the submission (such as “Motion for Discovery”).

(2) The signatory’s name, address, and telephone number.

(3) A signed certificate of service, specifying each address to which a copy of the submission is sent, the date on which it is sent, and the method of service.

(b) A party filing a submission with the ALJ must, at the time of filing, serve a copy of such submission on the opposing party. An intervenor filing a submission with the ALJ must, at the time of filing, serve a copy of the submission on all parties. Service must be made by mailing or hand delivering a copy of the submission to the opposing party. If a party is represented by an attorney, service must be made on the attorney.

§ 150.429 Computation of time and extensions of time.

(a) For purposes of this subpart, in computing any period of time, the time begins with the day following the act, event, or default and includes the last day of the period unless it is a Saturday, Sunday, or legal holiday observed by the Federal government, in which event it includes the next business day. When the period of time allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays observed by the Federal government are excluded from the computation.

(b) The period of time for filing any responsive pleading or papers is determined by the date of receipt (as defined in § 150.401) of the submission to which a response is being made.

(c) The ALJ may grant extensions of the filing deadlines specified in these regulations or set by the ALJ for good cause shown (except that requests for extensions of time to file a request for hearing may be granted only on the grounds specified in section § 150.405(b)).

§ 150.431 Acknowledgment of request for hearing.

After receipt of the request for hearing, the ALJ assigned to the case or someone acting on behalf of the ALJ will send a letter to the parties that acknowledges receipt of the request for

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hearing, identifies the docket number assigned to the case, provides instructions for filing submissions and other general information concerning procedures, and sets out the next steps in the case.

§ 150.435 Discovery.

(a) The parties must identify any need for discovery from the opposing party as soon as possible, but no later than the time for the reply specified in § 150.437(c). Upon request of a party, the ALJ may stay proceedings for a reasonable period pending completion of discovery if the ALJ determines that a party would not be able to make the submissions required by § 150.437 without discovery. The parties should attempt to resolve any discovery issues informally before seeking an order from the ALJ.

(b) Discovery devices may include requests for production of documents, requests for admission, interrogatories, depositions, and stipulations. The ALJ orders interrogatories or depositions only if these are the only means to develop the record adequately on an issue that the ALJ must resolve to decide the case.

(c) Each discovery request must be responded to within 30 days of receipt, unless that period of time is extended for good cause by the ALJ.

(d) A party to whom a discovery request is directed may object in writing for any of the following reasons:

(1) Compliance with the request is unduly burdensome or expensive.

(2) Compliance with the request will unduly delay the proceedings.

(3) The request seeks information that is wholly outside of any matter in dispute.

(4) The request seeks privileged information. Any party asserting a claim of privilege must sufficiently describe the information or document being withheld to show that the privilege applies. If an asserted privilege applies to only part of a document, a party withholding the entire document must state why the nonprivileged part is not segregable.

(e) Any motion to compel discovery must be filed within 10 days after receipt of objections to the party’s discovery request, within 10 days after the

time for response to the discovery request has elapsed if no response is received, or within 10 days after receipt of an incomplete response to the discovery request. The motion must be reasonably specific as to the information or document sought and must state its relevance to the issues in the case.

§ 150.437 Submission of briefs and proposed hearing exhibits.

(a) Within 60 days of its receipt of the acknowledgment provided for in § 150.431, the respondent must file the following with the ALJ:

(1) A statement of its arguments concerning CMS's notice of assessment (respondent's brief), including citations to the respondent's hearing exhibits provided in accordance with paragraph (a)(2) of this section. The brief may not address factual or legal bases for the assessment that the respondent did not identify as disputed in its request for hearing or in an amendment to that request permitted by the ALJ.

(2) All documents (including any affidavits) supporting its arguments, tabbed and organized chronologically and accompanied by an indexed list identifying each document (respondent's proposed hearing exhibits).

(3) A statement regarding whether there is a need for an in-person hearing and, if so, a list of proposed witnesses and a summary of their expected testimony that refers to any factual dispute to which the testimony will relate.

(4) Any stipulations or admissions.

(b) Within 30 days of its receipt of the respondent's submission required by paragraph (a) of this section, CMS will file the following with the ALJ:

(1) A statement responding to the respondent's brief, including the respondent's proposed hearing exhibits, if appropriate. The statement may include citations to CMS's proposed hearing exhibits submitted in accordance with paragraph (b)(2) of this section.

(2) Any documents supporting CMS's response not already submitted as part of the respondent's proposed hearing exhibits, organized and indexed as indicated in paragraph (a)(2) of this section (CMS's proposed hearing exhibits).

(3) A statement regarding whether there is a need for an in-person hearing

and, if so, a list of proposed witnesses and a summary of their expected testimony that refers to any factual dispute to which the testimony will relate.

(4) Any admissions or stipulations.

(c) Within 15 days of its receipt of CMS's submission required by paragraph (b) of this section, the respondent may file with the ALJ a reply to CMS's submission.

§ 150.439 Effect of submission of proposed hearing exhibits.

(a) Any proposed hearing exhibit submitted by a party in accordance with § 150.437 is deemed part of the record unless the opposing party raises an objection to that exhibit and the ALJ rules to exclude it from the record. An objection must be raised either in writing prior to the prehearing conference provided for in § 150.441 or at the prehearing conference. The ALJ may require a party to submit the original hearing exhibit on his or her own motion or in response to a challenge to the authenticity of a proposed hearing exhibit.

(b) A party may introduce a proposed hearing exhibit following the times for submission specified in § 150.437 only if the party establishes to the satisfaction of the ALJ that it could not have produced the exhibit earlier and that the opposing party will not be prejudiced.

§ 150.441 Prehearing conferences.

An ALJ may schedule one or more prehearing conferences (generally conducted by telephone) on the ALJ's own motion or at the request of either party for the purpose of any of the following:

(a) Hearing argument on any outstanding discovery request.

(b) Establishing a schedule for any supplements to the submissions required by § 150.437 because of information obtained through discovery.

(c) Hearing argument on a motion.

(d) Discussing whether the parties can agree to submission of the case on a stipulated record.

(e) Establishing a schedule for an in-person hearing, including setting deadlines for the submission of written direct testimony or for the written reports of experts.

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(f) Discussing whether the issues for a hearing can be simplified or narrowed.

(g) Discussing potential settlement of the case.

(h) Discussing any other procedural or substantive issues.

§ 150.443 Standard of proof.

(a) In all cases before an ALJ—

(1) CMS has the burden of coming forward with evidence sufficient to establish a prima facie case;

(2) The respondent has the burden of coming forward with evidence in response, once CMS has established a prima facie case; and

(3) CMS has the burden of persuasion regarding facts material to the assessment; and

(4) The respondent has the burden of persuasion regarding facts relating to an affirmative defense.

(b) The preponderance of the evidence standard applies to all cases before the ALJ.

§ 150.445 Evidence.

(a) The ALJ will determine the admissibility of evidence.

(b) Except as provided in this part, the ALJ will not be bound by the Federal Rules of Evidence. However, the ALJ may apply the Federal Rules of Evidence where appropriate; for example, to exclude unreliable evidence.

(c) The ALJ excludes irrelevant or immaterial evidence.

(d) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.

(e) Although relevant, evidence is excluded if it is privileged under Federal law.

(f) Evidence concerning offers of compromise or settlement made in this action will be inadmissible to the extent provided in the Federal Rules of Evidence.

(g) Evidence of acts other than those at issue in the instant case is admissible in determining the amount of any civil money penalty if those acts are used under §§ 150.317 and 150.323 of this part to consider the entity's prior

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record of compliance, or to show motive, opportunity, intent, knowledge, preparation, identity, or lack of mistake. This evidence is admissible regardless of whether the acts occurred during the statute of limitations period applicable to the acts that constitute the basis for liability in the case and regardless of whether CMS's notice sent in accordance with §§ 150.307 and 150.343 referred to them.

(h) The ALJ will permit the parties to introduce rebuttal witnesses and evidence.

(i) All documents and other evidence offered or taken for the record will be open to examination by all parties, unless the ALJ orders otherwise for good cause shown.

(j) The ALJ may not consider evidence regarding the willingness and ability to enter into and successfully complete a corrective action plan when that evidence pertains to matters occurring after CMS's notice under § 150.307.

§ 150.447 The record.

(a) Any testimony that is taken in-person or by telephone is recorded and transcribed. The ALJ may order that other proceedings in a case, such as a prehearing conference or oral argument of a motion, be recorded and transcribed.

(b) The transcript of any testimony, exhibits and other evidence that is admitted, and all pleadings and other documents that are filed in the case constitute the record for purposes of an ALJ decision.

(c) For good cause, the ALJ may order appropriate redactions made to the record.

§ 150.449 Cost of transcripts.

Generally, each party is responsible for 50 percent of the transcript cost. Where there is an intervenor, the ALJ determines what percentage of the transcript cost is to be paid for by the intervenor.

§ 150.451 Posthearing briefs.

Each party is entitled to file proposed findings and conclusions, and supporting reasons, in a posthearing brief. The ALJ will establish the schedule by which such briefs must be filed.

The ALJ may direct the parties to brief specific questions in a case and may impose page limits on posthearing briefs. Additionally, the ALJ may allow the parties to file posthearing reply briefs.

§ 150.453 ALJ decision.

The ALJ will issue an initial agency decision based only on the record and on applicable law; the decision will contain findings of fact and conclusions of law. The ALJ's decision is final and appealable after 30 days unless it is modified or vacated under § 150.457.

§ 150.455 Sanctions.

(a) The ALJ may sanction a party or an attorney for failing to comply with an order or other directive or with a requirement of a regulation, for abandonment of a case, or for other actions that interfere with the speedy, orderly or fair conduct of the hearing. Any sanction that is imposed will relate reasonably to the severity and nature of the failure or action.

(b) A sanction may include any of the following actions:

- (1) In the case of failure or refusal to provide or permit discovery, drawing negative fact inferences or treating such failure or refusal as an admission by deeming the matter, or certain facts, to be established.
- (2) Prohibiting a party from introducing certain evidence or otherwise advocating a particular claim or defense.
- (3) Striking pleadings, in whole or in part.
- (4) Staying the case.
- (5) Dismissing the case.
- (6) Entering a decision by default.
- (7) Refusing to consider any motion or other document that is not filed in a timely manner.
- (8) Taking other appropriate action.

§ 150.457 Review by Administrator.

(a) The Administrator of CMS (which for purposes of this subsection may include his or her delegate), at his or her discretion, may review in whole or in part any initial agency decision issued under § 150.453.

(b) The Administrator may decide to review an initial agency decision if it appears from a preliminary review of

the decision (or from a preliminary review of the record on which the initial agency decision was based, if available at the time) that:

- (1) The ALJ made an erroneous interpretation of law or regulation.
- (2) The initial agency decision is not supported by substantial evidence.
- (3) The ALJ has incorrectly assumed or denied jurisdiction or extended his or her authority to a degree not provided for by statute or regulation.
- (4) The ALJ decision requires clarification, amplification, or an alternative legal basis for the decision.
- (5) The ALJ decision otherwise requires modification, reversal, or remand.
- (c) Within 30 days of the date of the initial agency decision, the Administrator will mail a notice advising the respondent of any intent to review the decision in whole or in part.
- (d) Within 30 days of receipt of a notice that the Administrator intends to review an initial agency decision, the respondent may submit, in writing, to the Administrator any arguments in support of, or exceptions to, the initial agency decision.
- (e) This submission of the information indicated in paragraph (d) of this section must be limited to issues the Administrator has identified in his or her notice of intent to review, if the Administrator has given notice of an intent to review the initial agency decision only in part. A copy of this submission must be sent to the other party.
- (f) After receipt of any submissions made pursuant to paragraph (d) of this section and any additional submissions for which the Administrator may provide, the Administrator will affirm, reverse, modify, or remand the initial agency decision. The Administrator will mail a copy of his or her decision to the respondent.
- (g) The Administrator's decision will be based on the record on which the initial agency decision was based (as forwarded by the ALJ to the Administrator) and any materials submitted pursuant to paragraphs (b), (d), and (f) of this section.
- (h) The Administrator's decision may rely on decisions of any courts and

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other applicable law, whether or not cited in the initial agency decision.

§ 150.459 Judicial review.

(a) *Filing of an action for review.* Any responsible entity against whom a final order imposing a civil money penalty is entered may obtain review in the United States District Court for any district in which the entity is located or in the United States District Court for the District of Columbia by doing the following:

(1) Filing a notice of appeal in that court within 30 days from the date of a final order.

(2) Simultaneously sending a copy of the notice of appeal by registered mail to CMS.

(b) *Certification of administrative record.* CMS promptly certifies and files with the court the record upon which the penalty was assessed.

(c) *Standard of review.* The findings of CMS and the ALJ may not be set aside unless they are found to be unsupported by substantial evidence, as provided by 5 U.S.C. 706(2)(E).

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§ 150.461 Failure to pay assessment.

If any entity fails to pay an assessment after it becomes a final order, or after the court has entered final judgment in favor of CMS, CMS refers the matter to the Attorney General, who brings an action against the entity in the appropriate United States district court to recover the amount assessed.

§ 150.463 Final order not subject to review.

In an action brought under § 150.461, the validity and appropriateness of the final order described in § 150.459 is not subject to review.

§ 150.465 Collection and use of penalty funds.

(a) Any funds collected under § 150.461 are paid to CMS.

(b) The funds are available without appropriation until expended.

(c) The funds may be used only for the purpose of enforcing the HIPAA requirements for which the penalty was assessed.

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